FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: WILLOW CREST NURSING PAVILION, LTD.

Address: 515 NORTH MAIN (Number) SANDWICH (City) 60548 (Zip Code)

County: DEKALB

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

IDPA ID Number: 36-37418794-001

Date of Initial License for Current Owners: 1/11/1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	RICHARD S. SGARLATA, C.P.A
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,228	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,269	2,448	2,237	12,954	8
9	SNF/PED					9
10	ICF	14,187	7,887		22,074	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,456	10,335	2,237	35,028	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.50%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 2,190

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, L # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,002	15,805	7,824	193,631		193,631	(70)	193,561			1
2	Food Purchase		135,101		135,101	(12,737)	122,364	(396)	121,968			2
3	Housekeeping	91,392	17,658		109,050		109,050		109,050			3
4	Laundry	38,402	15,735		54,137		54,137	(822)	53,315			4
5	Heat and Other Utilities			88,518	88,518		88,518	498	89,016			5
6	Maintenance	37,619	30,201	46,249	114,069		114,069	(6,567)	107,502			6
7	Other (specify):*							416	416			7
8	**TOTAL General Services**	337,415	214,500	142,591	694,506	(12,737)	681,769	(6,941)	674,828			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,110,090	34,545	78,330	1,222,965		1,222,965	(2,714)	1,220,251			10
10a	Therapy			5,189	5,189		5,189		5,189			10a
11	Activities	47,748	4,027	2,053	53,828		53,828		53,828			11
12	Social Services	37,320	2,020	2,464	41,804		41,804		41,804			12
13	Nurse Aide Training							77	77			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,195,158	40,592	89,236	1,324,986		1,324,986	(2,637)	1,322,349			16
	C. General Administration											
17	Administrative	66,082			66,082		66,082	111,531	177,613			17
18	Directors Fees											18
19	Professional Services			183,618	183,618		183,618	(141,700)	41,918			19
20	Dues, Fees, Subscriptions & Promotions			58,738	58,738		58,738	(48,137)	10,601			20
21	Clerical & General Office Expenses	25,950	3,537	45,909	75,396		75,396	12,753	88,149			21
22	Employee Benefits & Payroll Taxes			255,442	255,442	12,737	268,179	(4,203)	263,976			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,378	1,378		1,378	403	1,781			24
25	Other Admin. Staff Transportation			1,285	1,285		1,285	18	1,303			25
26	Insurance-Prop.Liab.Malpractice			65,282	65,282		65,282	471	65,753			26
27	Other (specify):*							12,077	12,077			27
28	**TOTAL General Administration**	92,032	3,537	611,652	707,221	12,737	719,958	(56,787)	663,171			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,624,605	258,629	843,479	2,726,713		2,726,713	(66,365)	2,660,348			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

WILLOW CREST NURSING PAVILION, LTD.
0036533
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	12,737	
2	FOOD		12,737

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. #0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			72,237	72,237		72,237	131,775	204,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,850	9,850		9,850	180,400	190,250			32
33	Real Estate Taxes			49,489	49,489		49,489	1,171	50,660			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			4,840	4,840		4,840	4,870	9,710			35
36	Other (specify):*											36
37	**TOTAL Ownership**			616,416	616,416		616,416	(161,784)	454,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,036	74,880	148,916		148,916	(246)	148,670			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		74,036	138,564	212,600		212,600	(246)	212,354			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,624,605	332,665	1,598,459	3,555,729		3,555,729	(228,395)	3,327,334			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,455)	30		9
10	Interest and Other Investment Income	(12,301)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(396)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,890)	21		18
19	Entertainment				19
20	Contributions	(1,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(42,843)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,073)	20		28
29	Other-Attach Schedule	(37,804)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,262)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(107,133)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (107,133)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (228,395)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLOW CREST NURSING PAVILION, LTD.

ID# 0036533

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Discounts Earned	(724)	21	2
3	ICLTC - Donation	(166)	20	3
4	Prior Year Legal Fees	(116)	19	4
5	Prior Year - Maintenance	(4,823)	6	5
6	Prior Year - Nursing	(2,714)	10	6
7	Prior Year - Laundry	(822)	4	7
8	Prior Year - Dietary	(70)	1	8
9	Prior Year - Dues, Fees, Subsriptions	(1,558)	20	9
10	Prior Year - Office Expense	(10,718)	21	10
11	Prior Year - Employee Benefits	(4,203)	22	11
12	Franchise Tax (Bldg. Co.)	(200)	21	12
13	State Replacement Tax (Bldg. Co.)	(1,354)	21	13
14	Amortization of Mortgage Cost (Bldg. Co.)	(3,350)	31	14
15	Capitalized R&M	(6,986)	6	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(37,804)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS	
	A. General Services												(to Sch V, col.7)	
1	Dietary	(70)											(70)	1
2	Food Purchase	(396)											(396)	2
3	Housekeeping													3
4	Laundry	(822)											(822)	4
5	Heat and Other Utilities			498									498	5
6	Maintenance	(11,809)		2,542	2,700								(6,567)	6
7	Other (specify):*			72		344							416	7
8	**TOTAL General Services**	(13,097)		3,112	2,700	344							(6,941)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,714)											(2,714)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			77									77	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,714)		77									(2,637)	16
	C. General Administration													
17	Administrative				111,531								111,531	17
18	Directors Fees													18
19	Professional Services	(116)		(141,584)									(141,700)	19
20	Fees, Subscriptions & Promotions	(48,640)		503									(48,137)	20
21	Clerical & General Office Expenses	(21,386)	1,554	30,058	2,527								12,753	21
22	Employee Benefits & Payroll Taxes	(4,203)											(4,203)	22
23	Inservice Training & Education													23
24	Travel and Seminar			403									403	24
25	Other Admin. Staff Transportation			18									18	25
26	Insurance-Prop.Liab.Malpractice			471									471	26
27	Other (specify):*			3,984		8,093							12,077	27
28	**TOTAL General Administration**	(74,345)	1,554	(106,147)	114,058	8,093							(56,787)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,156)	1,554	(102,958)	116,758	8,437							(66,365)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(15,455)	145,148	2,082									131,775	30
31	Amortization of Pre-Op. & Org.	(3,350)	3,350											31
32	Interest	(12,301)	191,197	1,504									180,400	32
33	Real Estate Taxes			1,171									1,171	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			4,870									4,870	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(31,106)	(140,305)	9,627									(161,784)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(246)					(246)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(246)					(246)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(121,262)	(138,751)	(93,331)	116,758	8,437		(246)					(228,395)	45

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Willowcrest Building LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,000	Willowcrest Building LLC	100.00%	$	$ (480,000)	1
2	V	32	Interest Income				(2,738)	(2,738)	2
3	V	32	Interest Expense				193,935	193,935	3
4	V	30	Depreciation				145,148	145,148	4
5	V	31	Amortization - Mortgage Costs				3,350	3,350	5
6	V	21	Franchise Tax				200	200	6
7	V	21	State Replacement Tax				1,354	1,354	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 480,000			$ 341,249	$ * (138,751)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 498	$ 498	15
16	V	6	REPAIRS & MAINT.				2,542	2,542	16
17	V	7	EMP.BEN. - GEN. SERVICES				72	72	17
18	V	13	NURSES AIDE TRAINING				77	77	18
19	V	19	PROFESSIONAL FEES				1,201	1,201	19
20	V	20	DUES AND SUBSCRIPTIONS				503	503	20
21	V	21	CLERICAL & GENERAL				30,058	30,058	21
22	V	24	SEMINARS AND TRAVEL				403	403	22
23	V	25	ADMIN. STAFF TRANS.				18	18	23
24	V	26	INSURANCE				471	471	24
25	V	27	EMP.BEN. - GEN. ADMIN.				3,984	3,984	25
26	V	30	DEPRECIATION				2,082	2,082	26
27	V	32	INTEREST				1,504	1,504	27
28	V	33	REAL ESTATE TAXES				1,171	1,171	28
29	V	35	EQUIPMENT RENTAL				4,870	4,870	29
30	V	0					0		30
31	V	0					0		31
32	V	19	BOOKKEEPING SERVICES	142,785			0	(142,785)	32
33	V	0					0		33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 142,785			$ 49,454	$ * (93,331)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 2,700	$ 2,700	15
16	V	10	NURSING CMP - SUE G.				0		16
17	V	17	ADMIN. CMP. - M. MAUER				21,792	21,792	17
18	V	17	ADMIN. CMP. - M. AARON				27,914	27,914	18
19	V	17	ADMIN. CMP. - F. AARON				16,004	16,004	19
20	V	17	ADMIN. CMP. - A. STERN				17,581	17,581	20
21	V	17	ADMIN. CMP. - S. GOLDSTEIN				0		21
22	V	17	ADMIN. CMP. - S. KOPLIN				5,133	5,133	22
23	V	17	ADMIN. CMP. - D. MAGAFAS				5,766	5,766	23
24	V	17	ADMIN. CMP. - E. CASSON				0		24
25	V	17	ADMIN. CMP. - S. BOGEN				0		25
26	V	17	ADMIN. CMP. - S. LEVY				6,348	6,348	26
27	V	17	ADMIN. CMP. - A. STEINER				2,076	2,076	27
28	V	17	ADMIN. CMP. - NON-OWNER				8,917	8,917	28
29	V	21	CLERICAL CMP. - S. AARON				2,527	2,527	29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 116,758	$ * 116,758	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 344	$ 344	15
16	V	15	EMP. BEN.- SUE G.				0		16
17	V	27	EMP. BEN.- M. MAUER				609	609	17
18	V	27	EMP. BEN.- M. AARON				708	708	18
19	V	27	EMP. BEN.- F. AARON				1,974	1,974	19
20	V	27	EMP. BEN.- S. GOLDSTEIN				0		20
21	V	27	EMP. BEN.- S. KOPLIN				1,093	1,093	21
22	V	27	EMP. BEN.- D. MAGAFAS				949	949	22
23	V	27	EMP. BEN.- E. CASSON				0		23
24	V	27	EMP. BEN.- S. BOGEN				0		24
25	V	27	EMP. BEN.- S. LEVY				870	870	25
26	V	27	EMP. BEN.- A. STEINER				345	345	26
27	V	27	EMP. BEN.- NON-OWNER				1,199	1,199	27
28	V	27	EMP. BEN. - S. AARON				346	346	28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 8,437	$ * 8,437	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 5,189	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 5,189	$	15
16	V	22	EMPLOYEE BENEFITS	0	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	0		16
17	V	39	ANCILLARY SERVICES	74,878	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	74,878		17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 80,067			$ 80,067	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES, FEES & SUBSCRIPTIONS	$ 0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	$ 0	$	15
16	V	10	MEDICAL SUPPLIES	0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	0		16
17	V	39	ANCILLARY EXPENSE	936	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	690	(246)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 936			$ 690	$ * (246)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 7,131	PHARMCOR, L.L.C.	100.00%	$ 7,131	$	15
16	V	22	EMPLOYEE BENEFITS	1,375	PHARMCOR, L.L.C.	100.00%	1,375		16
17	V	39	ANCILLARY EXPENSE	68,702	PHARMCOR, L.L.C.	100.00%	68,702		17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,208			$ 77,208	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Marshall Mauer	Owner	Administrative	21.55	see attached	2	4.00	Dynamic alloc.	$ 21,792	17-7	1
2	Maurice Aaron	Owner	Administrative	23.79	see attached	2.3	4.60	Dynamic alloc.	27,914	17-7	2
3	Fred Aaron	Owner	Administrative	13.10	see attached	5	10.00	Dynamic alloc.	16,004	17-7	3
4	Abraham Stern	Owner	Administrative	0.00	see attached	0.4	0.80	Dynamic alloc.	17,581	17-7	4
5	Sharon Aaron	Relative	Clerical		see attached	2	5.00	Dynamic alloc.	2,527	21-7	5
6	Sue Koplin	Owner	Administrative	0.56	see attached	3.41	7.58	Dynamic alloc.	5,133	17-7	6
7	Dennis Nehmer	Owner	Maintenance	0.56	see attached	2	5.00	Dynamic alloc.	2,700	6-7	7
8	Diania Magafas	Owner	Administrative	0.56	see attached	3.16	7.02	Dynamic alloc.	5,766	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 99,417		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	707,726	15	$ 10,055	$ 16,071	35,028	$ 498	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	707,726	15	51,362		35,028	2,542	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	707,726	15	1,448		35,028	72	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	707,726	15	1,550		35,028	77	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	707,726	15	24,272		35,028	1,201	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	707,726	15	10,163		35,028	503	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	707,726	15	607,305	465,093	35,028	30,058	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	707,726	15	8,134		35,028	403	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	707,726	15	372		35,028	18	9
10	26	INSURANCE	PATIENT DAYS	707,726	15	9,517		35,028	471	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	707,726	15	80,498		35,028	3,984	11
12	30	DEPRECIATION	PATIENT DAYS	707,726	15	42,057		35,028	2,082	12
13	32	INTEREST	PATIENT DAYS	707,726	15	30,386		35,028	1,504	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	707,726	15	23,654		35,028	1,171	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	707,726	15	98,401		35,028	4,870	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,163		$ 49,454	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	54,000	54,000	2	2,700	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,209	32,209			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	14	435,842	435,842	2	21,792	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	14	558,156	558,156	2	27,914	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	50	7	160,040	160,040	5	16,004	5
6	17	ADMIN. CMP. - A. STERN	WGHTD. AVG. HOURS	8	14	351,664		0	17,581	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	179,079	179,079			7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	10	67,732	67,732	3	5,133	8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	10	82,127	82,127	3	5,766	9
10	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	45	2	47,882	47,882			10
11	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	119,320	119,320			11
12	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	14	126,974	126,974	3	6,348	12
13	17	ADMIN. CMP. - A. STEINER	WGHTD. AVG. HOURS	45	14	41,511	41,511	2	2,076	13
14	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	14	178,292	178,292	2	8,917	14
15	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	14	50,548	50,548	2	2,527	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,711		$ 116,758	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		6,887		2	344	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		2,883				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		12,175		2	609	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		14,155		2	708	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	50		19,744		5	1,974	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		18,514				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		14,423		3	1,093	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		13,516		3	949	8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	45		10,284				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		7,029				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		17,400		3	870	11
12	27	EMP. BEN.- A. STEINER	WGHTD. AVG. HOURS	45		6,891		2	345	12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		23,984		2	1,199	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		6,917		2	346	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 8,437	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						5,189	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							2
3	39	ANCILLARY SERVICES	DIRECT ALLOCATION						74,878	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 80,067	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION							1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION							2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						690	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 690	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.
Street Address 3116 S. OAK PARK
City / State / Zip Code BERWYN, IL 60402
Phone Number (708)795-7701
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						7,131	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						1,375	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						68,702	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 77,208	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOW CREST NURSING PAVILION, I # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Amrican National Bank		X	Mortgage			$ 3,350,000	$ 2,845,733			$ 193,935	1
2												2
3												3
4												4
5												5
	Working Capital											
6	American National Bank		X					275,000			9,850	6
7												7
8												8
9	TOTAL Facility Related						$ 3,350,000	$ 3,120,733			$ 203,785	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Interest Income										(12,301)	11
12	Dynamic allocation										1,504	12
13	Interest Income (Bldg. Co.)										(2,738)	13
14	TOTAL Non-Facility Related						$	$			$ (13,535)	14
15	TOTALS (line 9+line14)						$ 3,350,000	$ 3,120,733			$ 190,250	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTI # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	51,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	50,660	2
3. Under or (over) accrual (line 2 minus line 1).	$	(340)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	50,660	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	29,531	8
	1996	31,736	9
	1997	32,926	10
	1998	48,905	11
	1999	49,489	12

2000 Accrual = 1999 RE Tax + 3%
$49,489 x 103% = $51,000 (rounded)

Dynamic Allocation: $1171

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1998		$ 2,544,733	$ 65,250	39	$ 65,250	$	$ 133,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410	679	20	1,071	392	11,244	9
10	Various			1991	9,997	317	20	1,000	683	9,500	10
11	Various			1992	4,279	135	20	214	79	1,828	11
12	Various			1993	26,868	1,309	20	1,344	35	9,911	12
13	Various			1994	8,312	270	20	416	146	2,720	13
14	Various			1995	3,234	83	20	162	79	897	14
15	KITCHEN COOLER			1996	1,800	46	20	90	44	397	15
16	CEILING TILE			1996	2,267	58	20	113	55	471	16
17	HAND RAILS/BUMPERS			1996	6,201	159	20	310	151	1,266	17
18	LIGHT FIXTURES			1996	526	13	20	26	13	106	18
19	ROOF TOP COMPRESSOR			1996	1,378	35	20	69	34	316	19
20	FLOOR TILE			1996	504	13	20	25	12	104	20
21	DRYWALL			1996	4,735	121	20	237	116	968	21
22	HEAT & A/C ROOF			1997	2,619	67	20	131	64	513	22
23	LIGHT FIXTURES			1997	1,889	48	20	94	46	368	23
24											24
25	PAGE 12-1 REP TOTALS				21,955	563		627	64	4,600	25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				27,704	143		380	237	380	31
32	PAGE 12D TOTALS				85,714	997		2,365	1,368	2,365	32
33	PAGE 12C TOTALS				75,165	1,779		3,568	1,789	5,036	33
34	PAGE 12B TOTALS				65,662	2,522		3,286	764	5,637	34
35	PAGE 12A TOTALS				138,461	3,539		6,866	3,327	15,703	35
36	TOTAL (lines 4 thru 35)				$ 3,055,413	$ 78,146		$ 87,644	$ 9,498	$ 207,549	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER			1997	2,718	70	20	136	66	533	9
10	ROOF WORK			1997	10,003	256	20	500	244	1,542	10
11	HANDRAIL			1997	1,963	50	20	98	48	343	11
12	WALK IN FREEZER			1997	7,558	194	20	378	184	1,323	12
13	PLUMBING WORK			1997	26,794	687	20	1,340	653	4,243	13
14	PAINT & DECORATING			1997	9,772		20	489	489	489	14
15	NURSES STATION			1997	5,183	133	20	259	126	1,036	15
16	SPRINKLER HEADS			1998	974	25	20	49	24	110	16
17	BOILER REPAIR			1998	1,973	51	20	99	48	264	17
18	SHADE			1998	404	10	20	20	10	52	18
19	HANDRAILS			1998	14,756	378	20	738	360	1,476	19
20	SPRINKLER HEADS			1998	703	18	20	35	17	73	20
21	CEILING FIXTURE			1998	1,134	29	20	57	28	138	21
22	CEILING FIXTURES & L			1998	2,479	64	20	124	60	310	22
23	HANDRAILS & GUARDS			1998	6,707	172	20	335	163	810	23
24	CEILING TILE			1998	1,732	44	20	87	43	218	24
25	A/C COMPRESSORS			1998	404	10	20	20	10	43	25
26	COVE BASE			1998	379	10	20	19	9	48	26
27	AIR CONDITIONER			1999	1,098	269	20	55	(214)	138	27
28	FLOOR TILES			1999	2,364	61	20	118	57	148	28
29	GENERATOR SYSTEM			1999	29,189	748	20	1,459	711	1,824	29
30	SHOWER TILE			1999	591	15	20	15		16	30
31	ELEVATOR REPAIRS			1999	311	8	20	8		9	31
32	ELEVATOR REPAIRS			1999	1,031	26	20	26		29	32
33	ELEVATOR REPAIRS			1999	435	11	20	11		12	33
34	NEW FLOORS			1999	2,310	59	20	116	57	155	34
35	GENERATOR SYSTEM UPG			1999	5,496	141	20	275	134	321	35
36	TOTAL (lines 4 thru 35)				$ 138,461	$ 3,539		$ 6,866	$ 3,327	$ 15,703	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AIR CONDITIONER			1999	1,098	269	20	55	(214)	147	9
10	AIR CONDITIONER			1999	1,098	269	20	55	(214)	128	10
11	AIR CONDITIONER			1999	1,098	269	20	55	(214)	128	11
12	BORDER			1999	192		20	10	10	10	12
13	WALLPAPER			1999	586		20	29	29	29	13
14	CEILING TILE			1999	236	6	20	12	6	15	14
15	AIR CONDITIONER			1999	1,098	269	20	55	(214)	156	15
16	TILE			1999	2,087	54	20	104	50	156	16
17	WALLPAPER			1999	1,245		20	62	62	62	17
18	NEW ENT EDGING			1999	1,286	33	20	64	31	85	18
19	WALL GUARD			1999	1,170		20	59	59	59	19
20	DOOR/FRAME			1999	553	14	20	28	14	51	20
21	GENERATOR			1999	14,595	374	20	730	356	1,338	21
22	CURTAINS/DRAPES			1999	2,013	52	20	101	49	160	22
23	CAMERAS & MONITORS			1999	2,750	71	20	138	67	253	23
24	SOLFIT & FACCIA			1999	4,970	127	20	249	122	394	24
25	FLOOR TILES			1999	2,022	52	20	101	49	126	25
26	TILE			1999	302	8	20	15	7	23	26
27	SOLFIT & FACCIA			1999	5,322	136	20	266	130	421	27
28	HAND RAILS & BUMPERS			1999	4,438	114	20	222	108	407	28
29	COVE CASE			1999	459	12	20	23	11	31	29
30	DOOR			1999	557	14	20	28	14	54	30
31	PLUMBING WORK			1999	1,040		20	52	52	52	31
32	COVE BASE			1999	459	12	20	23	11	29	32
33	WINDOW TREATMENTS			1999	5,002	128	20	250	122	396	33
34	NURSES STATION			1999	9,316	239	20	466	227	893	34
35	WALLPAPER			1999	670		20	34	34	34	35
36	TOTAL (lines 4 thru 35)				$ 65,662	$ 2,522		$ 3,286	$ 764	$ 5,637	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ENTRANCE DOOR			1999	1,898	49	20	95	46	182	9
10	DYNALOCK SYSTEM			1999	4,966	127	20	248	121	475	10
11	CUBICLE			1999	506	13	20	25	12	50	11
12	HOT WATER BOILER			1999	9,018	231	20	451	220	902	12
13	HOT WATER BOILER			1999	6,563	168	20	328	160	656	13
14	BATHROOM FIXTURES			1999	600		20	30	30	30	14
15	COOLING REPAIRS			1999	542		20	27	27	27	15
16	ROOM SIGNAGES			1999	1,323		20	66	66	66	16
17	AIR CONDITIONER			1999	1,098	269	20	55	(214)	165	17
18	WALLPAPER			1999	5,192		20	260	260	260	18
19	FIRE ALARM			1999	1,140		20	57	57	57	19
20	ATRIUM A/C			1999	5,755	148	20	288	140	528	20
21	SHOWER REMODELING			2000	638	15	20	32	17	32	21
22	CUBICLE TRACKS&CURTA			2000	507	10	20	21	11	21	22
23	TILES			2000	507	10	20	21	11	21	23
24	CUBICLE HOOKS			2000	112	2	20	5	3	5	24
25	SECURITY CAMERAS			2000	1,925	39	20	80	41	80	25
26	WALLPAPER		*	2000	3,066		20	51	51	51	26
27	COVE BASE			2000	462	11	20	21	10	21	27
28	SHOWER REMODELING			2000	673	16	20	34	18	34	28
29	FIRE DOORS			2000	1,939	48	20	97	49	97	29
30	LIGHTING		*	2000	1,770	21	20	45	24	45	30
31	KICK PLATES		*	2000	392	5	20	12	7	12	31
32	TILE & COVE BASE			2000	838	18	20	39	21	39	32
33	SHOWER REMODELING			2000	405	7	20	15	8	15	33
34	ROOF RENOVATION			2000	23,155	569	20	1,158	589	1,158	34
35	BUZZERS			2000	175	3	20	7	4	7	35
36	TOTAL (lines 4 thru 35)				$ 75,165	$ 1,779		$ 3,568	$ 1,789	$ 5,036	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER TANK REPAIR			2000	667	12	20	25	13	25	9
10	ELEVATOR DOOR EDGE			2000	2,270	36	20	76	40	76	10
11	TILE			2000	699	13	20	26	13	26	11
12	BOILER REPAIR	*		2000	458	7	20	13	6	13	12
13	DEFROST CLOCK	*		2000	725	2	20	6	4	6	13
14	SECURITY MONITOR	*		2000	290	4	20	10	6	10	14
15	PARKING LOT PAVING			2000	8,775		20	256	256	256	15
16	BATHROOM TILE			2000	30,000	417	20	875	458	875	16
17	BATHROOM TILE			2000	15,000	209	20	438	229	438	17
18	DINING ROOM TILES	*		2000	4,500	62	20	131	69	131	18
19	TILE	*		2000	210	3	20	6	3	6	19
20	WALL GUARDS	*		2000	589	3	20	7	4	7	20
21	WATER HEATER REPAIR			2000	2,081	42	20	87	45	87	21
22	WALL BORDERS	*		2000	1,772	9	20	22	13	22	22
23	TILE			2000	1,791	40	20	83	43	83	23
24	WATER PUMP	*		2000	1,567	15	20	33	18	33	24
25	TILE	*		2000	1,792	17	20	38	21	38	25
26	FIXTURES	*		2000	1,587	12	20	26	14	26	26
27	COVE BASE	*		2000	318	2	20	5	3	5	27
28	TILE	*		2000	2,599	20	20	43	23	43	28
29	FAUCETS	*		2000	699	5	20	12	7	12	29
30	BATHROOM SINKS	*		2000	538	4	20	9	5	9	30
31	BATHROOM SINKS&FAUCE	*		2000	1,072	8	20	18	10	18	31
32	WALL BORDERS	*		2000	1,828	6	20	15	9	15	32
33	SPRINKLER REPAIR	*		2000	1,625	19	20	41	22	41	33
34	COVE BASE	*		2000	837	4	20	11	7	11	34
35	ROOF REPAIR	*		2000	1,425	26	20	53	27	53	35
36	TOTAL (lines 4 thru 35)				$ 85,714	$ 997		$ 2,365	$ 1,368	$ 2,365	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SOUND SYSTEM	*		2000	840	5	20	11	6	11	9
10	TILE	*		2000	307	2	20	5	3	5	10
11	TILE	*		2000	205	1	20	3	2	3	11
12	TILE			2000	1,912	39	20	80	41	80	12
13	FIRE PANELS	*		2000	2,887	9	20	24	15	24	13
14	CARPETING	*		2000	5,270	28	20	66	38	66	14
15	TILING & DRYWALL	*		2000	5,900	6	20	25	19	25	15
16	COOLER REPAIR	*		2000	719	1	20	3	2	3	16
17	DOOR	*		2000	320		20	1	1	1	17
18	WALLPAPER	*		2000	3,919		20	49	49	49	18
19	TILE	*		2000	5,425	52	20	113	61	113	19
20											20
21											21
22	* additions after capital projection was filed										22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 27,704	$ 143		$ 380	$ 237	$ 380	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Dynamic alloc.	$ 21,955	$ 563	35	$ 627	$ 64	$ 4,600	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 21,955	$ 563		$ 627	$ 64	$ 4,600	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 431,144	$ 81,098	$ 82,120	$ 1,022		$ 218,564	37
38	Current Year Purchases	255,938	46,491	27,866	(18,625)		91,394	38
39	Fully Depreciated Assets	72,789	11,905	3,497	(8,408)		3,497	39
40								40
41	TOTALS	$ 759,871	$ 139,494	$ 113,483	$ (26,011)		$ 313,455	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		94 Dodge Wagon	1994	$ 27,533	$ 1,675	$ 2,753	$ 1,078	10	$ 17,665	42
43	Dynamic allocation		2000	787	151	131	(20)		131	43
44										44
45										45
46	TOTALS			$ 28,320	$ 1,826	$ 2,884	$ 1,058		$ 17,796	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,171,463	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 219,466	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 204,011	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (15,455)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 538,800	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

WILLOW CREST NURSING PAVILION, LTD.
0036533
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Willow Crest Nursing Pavilion, LTD	13,109		1,043	1,043	13,109
Dynamic Healthcare	12,035	1,200	1,179	(21)	5,710
Willow Crest LLC	406,000	79,898	79,898		199,745
TOTALS	431,144	81,098	82,120	1,022	218,564
LINE 29: CURRENT YEAR					
Willow Crest Nursing Pavilion, LTD	255,104	46,324	27,824	(18,500)	91,352
Dynamic Healthcare	834	167	42	(125)	42
Willow Crest LLC					
TOTALS	255,938	46,491	27,866	(18,625)	91,394
LINE 30: FULLY DEPRECIATED					
Willow Crest Nursing Pavilion, LTD	72,789	11,905	3,497	(8,408)	3,497
Dynamic Healthcare					
Willow Crest LLC					
TOTALS	72,789	11,905	3,497	(8,408)	3,497
TOTALS (Should Tie to Totals on Page 13)					
Willow Crest Nursing Pavilion, LTD	341,002	58,229	32,364	(25,865)	107,958
Dynamic Healthcare	12,869	1,367	1,221	(146)	5,752
Willow Crest LLC	406,000	79,898	79,898		199,745
TOTALS	759,871	139,494	113,483	(26,011)	313,455

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 9,710 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE [ ]

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE [ ]

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				Dynamic
8	Nurse Aide Competency Tests				allocation
9	TOTALS	$	$	$	$ 77
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 34,520	$		$ 34,520	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			71			71	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			40,288			40,288	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				65,200		65,200	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					8,836		8,836	13
14	TOTAL			$ 0		$ 74,879	$ 74,036		$ 148,915	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	4,439
2	Radiology	780
3	Laboratory	3,065
4	Equipment Rental	552
5		
6		
7		
8		
9		
10		
		8,836

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 119,883	$ 202,546	1
2	Cash-Patient Deposits	32,251	32,251	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	337,787	337,787	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,403	27,403	6
7	Other Prepaid Expenses	2,685	2,685	7
8	Accounts Receivable (owners or related parties)	180,105	191,705	8
9	Other(specify): See supplemental schedule	18,384		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 718,498	$ 794,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cos	452,758	452,758	15
16	Equipment, at Historical Cost	376,355	782,355	16
17	Accumulated Depreciation (book methods)	(257,778)	(597,252)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		26,660	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 571,335	$ 3,537,113	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,289,833	$ 4,331,490	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 230,748	$ 230,748	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,251	32,251	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,221	120,221	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,332	2,332	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000	51,000	32
33	Accrued Interest Payable	2,322	12,245	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,782	4,782	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	19,187	19,187	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 462,843	$ 472,766	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	275,000	275,000	39
40	Mortgage Payable		2,845,733	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 275,000	$ 3,120,733	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 737,843	$ 3,593,499	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 551,990	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,289,833	$ #REF!	48

*(See instructions.)

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. **#** 0036533 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	18,384	
	18,384	

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to Others	19,187	19,187
	19,187	19,187

OTHER NON CURRENT ASSETS:		
Mortgage Costs (net of amortization)		26,660
		26,660

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 513,555	1
2	Restatements (describe):		2
3	1999 late journal entry - State Income Tax	(1,864)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 511,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	179,499	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(139,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 40,299	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 551,990	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	WILLOW CREST NURSING PAVILIC #	0036533	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		511,691
Adjustments:		
		-
		-
		-
1999 late journal entry - State Income tax		1,864
Total adjustments		1,864
Balance - Beginning of Year		513,555
Equity(Deficit) from Page 17 Col 1		551,990
Related Party		
Equity(Deficit)	47250	
Income	138751	
		186,001
Combined Equity - End of Year		737,991

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,704,098	1
2	Discounts and Allowances for all Levels	(438,256)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,265,842	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,140	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 320,140	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,801	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,220	19
20	Radiology and X-Ray		20
21	Other Medical Services	18,200	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 136,221	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,301	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,301	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule	724	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,735,228	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	694,506	31
32	Health Care	1,324,986	32
33	General Administration	707,221	33
	B. Capital Expense		
34	Ownership	616,416	34
	C. Ancillary Expense		
35	Special Cost Centers	148,916	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,555,729	40
41	**Income before Income Taxes (line 30 minus line 40)****	179,499	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 179,499	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLOW CREST NURSING PAVI # 0036533 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Discounts Earned (adjusted out on page 5)	724
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	724

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,613	1,728	$ 36,128	$ 20.91	1
2	Assistant Director of Nursing	1,459	1,475	30,373	20.59	2
3	Registered Nurses	6,518	6,968	120,099	17.24	3
4	Licensed Practical Nurses	15,621	16,817	282,018	16.77	4
5	Nurse Aides & Orderlies	55,437	57,461	628,153	10.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,004	2,143	22,314	10.41	9
10	Activity Assistants	3,959	3,968	25,434	6.41	10
11	Social Service Workers	4,726	5,173	37,320	7.21	11
12	Dietician					12
13	Food Service Supervisor	1,922	2,084	29,995	14.39	13
14	Head Cook	3,709	3,802	39,505	10.39	14
15	Cook Helpers/Assistants	13,518	13,901	100,502	7.23	15
16	Dishwashers					16
17	Maintenance Workers	3,293	3,400	37,619	11.06	17
18	Housekeepers	12,954	13,499	91,392	6.77	18
19	Laundry	6,448	6,685	38,402	5.74	19
20	Administrator	2,385	2,678	66,082	24.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,305	2,437	25,950	10.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,182	1,266	13,318	10.52	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	139,053	145,485	$ 1,624,604 *	$ 11.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	209	$ 7,824	1-3	35
36	Medical Director	monthly	1,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,157	10-3	39
40	Physical Therapy Consultant	52	1,811	10A-3	40
41	Occupational Therapy Consultant	96	3,378	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,053	11-3	44
45	Social Service Consultant	44	2,464	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	451	$ 20,887		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	94	$ 3,733	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,614	72,439	10-3	52
53	TOTAL (lines 50 - 52)	3,708	$ 76,172		53

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Bohannon (1/1-7/31)	Administrator	0	$ 40,185
Pam Ingold (8/12-12/31)	Administrator	0	25,897
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,082

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	$ 878
Econocare	Purchasing Consultant	2,088
Frost, Ruttenberg & Rothblatt	Accounting	25,550
Sachnoff & Weaver, Ltd	Legal	9,723
Littler Mendelson	Legal	245
Health Data Systems	Data Processing	2,350
Dynamic Healthcare	Bookkeeping Services	142,785
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 183,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,072
Unemployment Compensation Insurance	14,564
FICA Taxes	123,950
Employee Health Insurance	68,708
Employee Meals	12,737
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,945
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,976

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,522
Health Care Worker Background Check	292
(Indicate # of checks performed 40)	
Licenses & Fees	1,200
Dues & Subscriptions	3,884
Advertising & Promotion	42,843
Yellow Page Advertising	4,073
Dynamic allocation	503
Less: Public Relations Expense	( )
Non-allowable advertising	(42,843)
Yellow page advertising	(4,073)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,378
Dynamic allocation	403
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,781

**See instructions.

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Wallpaper	12/96	$ 4,919	3	$ 1,640	$ 1,640	$ 1,503	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,919		$ 1,640	$ 1,640	$ 1,503	$	$	$	$	$	$

Facility Name & ID Number WILLOW CREST NURSING PAVILION, LTD. # 0036533 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council on Long Term Care $3688**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **687** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **63,684**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit
on Schedule V. $ **12,737** Has any meal income been offset against
related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw